

Case Number:	CM15-0160957		
Date Assigned:	08/27/2015	Date of Injury:	08/24/2008
Decision Date:	09/30/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/17/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 38 year old female, who sustained an industrial injury on 6-24-2008. She reported falling off her bicycle, landing on her left hip, left knee and head. Diagnoses have included neck sprain-strain, lumbar sprain-strain, chronic pain syndrome and postconcussion syndrome. Treatment to date has included physical therapy and medication. According to the progress report dated 7-27-2015, the injured worker complained of ongoing chronic pain in her head, neck, back and left hip. She rated her current pain level as one out of ten. Current medications included Buprenorphine, Relafen, Zanaflex and Lorazepam. Objective findings revealed the injured worker to appear to be in discomfort. There was decreased, painful range of motion of the neck and low back. Authorization was requested for physical therapy for the low back and chiropractic treatment for the neck and low back.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Physical Therapy, twice weekly for the low back for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2008 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy, twice weekly for the low back for three weeks is not medically necessary and appropriate.

Chiropractic therapy, twice weekly for the neck and low back, for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care, Manual Therapy & Manipulation, Treatment, Pages 58-60.

Decision rationale: MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic 2008 injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved work/functional status from treatment already rendered by previous chiropractic care. Clinical exam remains unchanged without acute flare-up or new red-flag findings. It appears the patient has received an extensive conservative treatment trial; however, remains unchanged without functional restoration approach. The Chiropractic therapy, twice weekly for the neck and low back, for three weeks is not medically necessary and appropriate.